Proceedings

GOVERNOR'S FIFTH CONFERENCE ON THE HANDICAPPED

Terre Haute, Indiana—October 6-7, 1965

THE GOVERNOR'S FIFTH CONFERENCE ON THE HANDICAPPED

Sponsored by

The Commission for the Handicapped
Indiana State Board of Health
Andrew C. Offutt, M.D.
State Health Commissioner

Cooperating Agencies

Indiana State Department of Public Welfare
State Department of Public Instruction
Division of Vocational Rehabilitation
Division of Special Education
Indiana Department of Mental Health
Indiana Employment Security Division
Veterans Administration

PROCEEDINGS OF THE

GOVERNOR'S FIFTH CONFERENCE ON THE HANDICAPPED

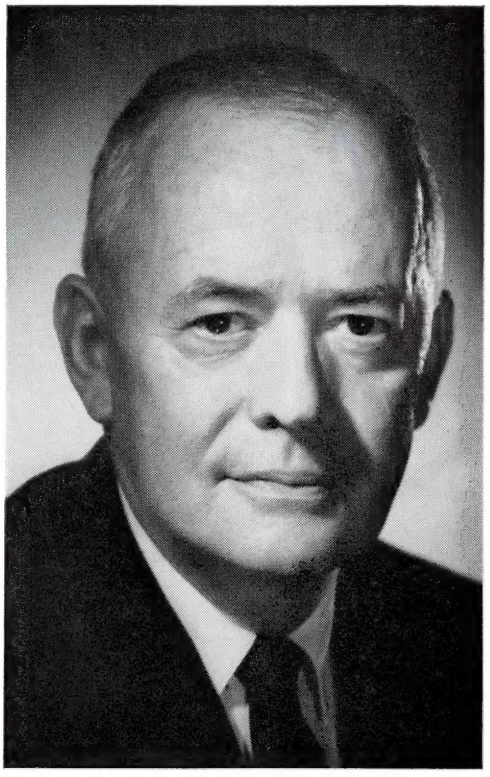
October 6-7, 1965

STUDENT UNION BUILDING
INDIANA STATE UNIVERSITY
Terre Haute, Indiana

What's New In Rehabilitation

The Governor's

FIFTH CONFERENCE ON THE HANDICAPPED



ROGER D. BRANIGIN, *Governor*
State of Indiana

REHABILITATION

"Rehabilitation is the process of decreasing the dependency of a handicapped individual and increasing his ability to participate in the normal processes of living by developing to the greatest extent possible those abilities needed in his individual situation."

Foreword

THE purpose of the Governor's Fifth Conference on the Handicapped, as stated by Governor Branigin, was to discuss "New Legislative Programs Affecting the Handicapped."

The previous conferences which brought together dedicated persons from the many public and private organizations which serve the disabled, have focused attention upon the problems and needs of this group.

Through these conferences, much has been gained in understanding and in cooperation among these organizations concerned with rehabilitation.

Only through understanding of areas of responsibility and continued cooperative effort can progress in all areas of rehabilitation occur.

The purpose of this conference was realized. It was inspiring to observe the excellent rapport of those who responded to the Governor's invitation, and to share the enthusiasm which prevailed.

It is our sincere hope that meeting the needs of the handicapped in the future will offer the challenge that it has in the past and that those concerned will maintain their interest and enthusiasm in searching for solutions to the problems in the area of rehabilitation.

ANDREW C. OFFUTT, M.D.
State Health Commissioner

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Crossroads Rehabilitation Center
Indianapolis

ACTING EXECUTIVE SECRETARY

Ray Benson, Acting Director
Division for the Handicapped
Indiana State Board of Health
Indianapolis

Contents—

PROGRAM

Wednesday, October 6

STUDENT CENTER
Indiana State University
TERRE HAUTE

Morning: West Ballroom

9:00 Registration and Coffee Hour—Student Lounge

9:45 Presiding: Neal Baxter, M.D., Chairman, Commission for the Handicapped, Bloomington, Indiana

Invocation: Reverend Alan Harlan, St. Stephens Episcopal Church, Terre Haute, Indiana

Welcome: A. C. Offutt, M.D., State Health Commissioner, Indianapolis, Indiana

10:00 Address: "Economic Opportunity and Implications for Rehabilitation"

Speaker: Robert Shackford, District Director, Community Action Programs, Office of Economic Opportunity, Chicago, Illinois

11:30 First Luncheon—East Ballroom

Presiding: Neal Baxter, M.D., Chairman, Commission for the Handicapped, Bloomington, Indiana

Invocation: Reverend Louis B. Gerhardt, First Congressional Church, Terre Haute, Indiana

Introduction: Carl W. Fuller, Ph.D., Assistant Director, Audiology and Speech, Indiana University Medical Center, Indianapolis, Indiana

Address: "International Coding"

Speaker: Maya Riviere, D.Phil. (Oxon.), Executive Director, Rehabilitation Codes, Inc., New York, N. Y.

Afternoon:

2:00 Subject: "New Legislation and Programs Affecting the Handicapped"

Panel I

Moderator: Tony Milazzo, Acting Director, Program for Special Needs, Department of Health, Education and Welfare, Office of Education, Washington, D. C.

Participants: Leslie Brinegar, Acting Director, Special Education, State Department of Public Instruction, Indianapolis, Indiana

Gayle S. Eads, Director, Vocational Rehabilitation, State Department of Public Instruction, Indianapolis, Indiana

Keith Collins, Assistant Chief, Employment Service, Indiana Employment Security Division, Indianapolis, Indiana

W. A. Williams, Director, Vocational Education Division, State Department of Public Instruction, Indianapolis, Indiana

Robert W. Spaulding, Director, Division on Mental Retardation, Department of Mental Health, Indianapolis, Indiana

3:00 Coffee Break—Student Lounge

3:15 Panel II

Moderator: Otis R. Bowen, M.D., House Minority Leader, Indiana General Assembly, Bremen, Indiana

Participants: Evelyn Bell, Administrative Assistant, State Department of Public Welfare, Indianapolis, Indiana

Stewart T. Ginsberg, M.D., Mental Health Commissioner, Indianapolis, Indiana

Freeman D. Ketron, President, Indiana Rehabilitation Association, Indianapolis, Indiana

A. C. Offutt, M.D., State Health Commissioner, Indianapolis, Indiana

Evening:

6:00 Banquet—East Ballroom

Presiding: Neal Baxter, M.D., Chairman, Commission for the Handicapped, Bloomington, Indiana

Invocation: Rabbi Bernard Cohen, The United Hebrew Congregation, Terre Haute, Indiana

Entertainment:

Presentation of the Governor's Rehabilitation Awards — The Honorable Roger D. Branigin, Governor of Indiana

Address: Lee Hamilton, United States Congressman

Thursday, October 7

STUDENT CENTER

Morning:

8:30 Registration—Coffee—Student Lounge

9:00 Special Interest Session

1. American Cancer Society, Indiana Division, Inc., Fern Weir, Chairman

   Demonstration: "The Teaching of Esophageal Speech to a Laryngectomy," James Shank, M.D., Indiana University Medical Center; Margaret Roe, Ed.D., Speech Department, Indiana State University

2. Division on Alcoholism, Department of Mental Health, Bruce E. Falkey, Chairman

   General Discussion: Problems of Alcohol and Alcoholism in Indiana

3. International Coding:

   Question and Answer: Carl W. Fuller, Ph.D., Assistant Director, Audiology and Speech Clinic, Indiana University Medical Center, Indianapolis, Indiana

   Resource Consultant:

   Maya Riviere, Executive Director, Rehabilitation Codes

4. Indiana Association of Retarded Children

   Owen C. Wemhoff, Executive Director, Chairman

   Subject: "IARC and its Role in Providing Services for the Mentally Retarded" (A slide presentation)

5. Indiana Chapter, National Multiple Sclerosis Society, V. L. Tatlock, Chairman

   Subject: "The Problems of the Multiple Sclerosis Patient in Indiana"

6. Indiana State Parent's Group for Deaf Children, Mary Jane Rhodes, Chairman

   Subject: "Objectives of a State Organization for the Deaf"

   Discussion Leaders: D. H. Porkorny, Hank Vogtmann

7. Indiana Association Sheltered Workshops and Homebound Programs, Inc.

   Presiding: Kenneth M. Curtin, President, Business Meeting

   Presiding: Howard G. Lytle, D.D., L.H.D., Executive Secretary

   Subject: "Federal Wage and Hour Certification"

   Speaker: Earl Halverson, Regional Director, Wage and Hour Division, U. S. Department of Labor, Washington, D. C.

   Presiding: Vern Hazzard, Vice-President, Indiana Association Sheltered Workshops and Homebound Programs

   Subject: "Contract Procurement Practices of Sheltered Workshops"

   Speaker: Michael Dolinck, Project Director, National Society for Crippled Children and Adults

8. Indiana Society for Crippled Children and Adults

   Ralph B. Werking, Jr., Administrative Assistant, Chairman

Subject: "The Development of Service Directories and Promotion and Recruitment for Health Careers"

9. Muscular Dystrophy Association of America, Inc., Richard H. Wenzel, District Director, M.S.A.A., Chairman

   Subject: "Diagnosis and Treatment of Myopathies"

   Speaker: Felix Millan, M.D., Director, Department of Physical Medicine, Marion County General Hospital, Indianapolis, Indiana

10. Indiana Society for the Prevention of Blindness, Marcia Butcher, Chairman

11:30 Second Luncheon

Presiding: Neal Baxter, M.D., Chairman, Commission for the Handicapped, Bloomington, Indiana

Invocation: Reverend Joseph Buchan, Principal, Paul Schulte Roman Catholic High School, Terre Haute, Indiana

Introduction: Kenneth Chapman, Director of Planning, Community Service Council, Metropolitan Indianapolis

Address: "The Changing Philosophy of Society in the Role of Government as it Relates to the Handicapped"

Speaker: Rowland Allen, Chairman, Rehabilitation Advisory Committee, Community Service Council of Metropolitan Indianapolis

Introduction

Opening Remarks:

GAYLE S. EADS, Director
Division of Vocational
Rehabilitation, State
Department of Public Instruction

May I now call to order the first plenary session of the Governor's Fifth Conference on the Handicapped.

Today and tomorrow you are guests of Indiana State University which has graciously extended its facilities to the Commission for this conference.

May I take this opportunity to thank the University for the privilege of holding the conference here. We are certain that you will all enjoy your visit to the campus and participation in the conference.

The theme for this year's conference is "What's New In Rehabilitation?" The program which has been arranged will deal with various influences and impacts on this timely and complex problem.

We sincerely hope you will be in attendance at each of the ensuing plenary sessions to benefit from the wisdom and insight our speakers will offer.

Address of Welcome

A. C. Offutt, M.D.
State Health Commissioner
Indianapolis

It is a pleasure for me to join with you and to share in the discussion of such a timely topic, "What's New In Rehabilitation."

In the past fifteen years we have seen a rather tremendous advancement in all phases of rehabilitation. The advances we have seen have arisen from cooperation of institutions, professions, organizations, and the individual himself, in an effort to provide a complete and effective program in rehabilitation.

Today, there is an even greater challenge for a continuation of this concerted effort. With the increased activity of the federal government in all areas of health and rehabilitative services, rehabilitation workers must be involved in developing rehabilitation services where decision-making is involved, and further, to work effectively with leadership in long range planning.

We must keep in mind that successful rehabilitation programs are built upon the interrelationship between medical, social, vocational, and economic efforts. Coordination of effort is necessary between different services, financing assured, facilities available, and equipment and staff provided.

Everyone who is engaged in providing for the welfare of human beings has the unavoidable responsibility of making others understand what he is trying to do. It is not possible to spell out a formula of progress for anyone. The rules have not changed but the tempo has increased. The most pressing dimension of our lives today is time. In order that we may broaden the expanse of time, we must broaden our vision. We must develop intelligent concepts and a grasp of both science and the humanities because we must know the past in order to understand our vision of the future.

The rehabilitation worker today is charged with even greater responsibilities for effectively utilizing the resources available to make it possible for the restoration of the disabled to the fullest potential for living.

Address of the Chairman

NEAL E. BAXTER, M.D., Chairman
Commission for the Handicapped
Bloomington

We meet here today to participate in the Governor's Fifth Conference on the Handicapped. This and the previous conferences were not initiated just for the sake of a conference but they were the result of a series of events.

The Indiana Planning Committee on Rehabilitation was formed in 1947 by representatives of several official and volunteer agencies for the purpose of coordinating the rehabilitation efforts of the various member agencies. This Committee was active for ten years, working on an unofficial and volunteer basis. It was finally decided by the Committee that a full-time official agency was needed to carry on this work and in 1957 legislation was prepared which was designed to create a State Commission for the Handicapped. This legislation was not enacted.

The Governor's Commission for physically Handicapped Children was created by the Indiana General Assembly, in 1947. The purpose of this Commission as set forth in the legislation was: to study conditions relating to physically handicapped children in Indiana and in other states with a view toward improving the facilities and services

available to such children through recommendations to administrative and legislative bodies.

After the failure of the 1957 legislative proposal, the Governor's Commission for Physically Handicapped Children, feeling this type of approach was vital to the growth of the total rehabilitation program in Indiana, reworked the legislation and presented it to the 1959 General Assembly, where it passed, becoming Chapter 91 of the Acts of 1959.

The purpose of this legislation as stated in the Act is: "to provide a facility charged with the responsibility of providing direction and leadership in the development of a comprehensive rehabilitation program for the handicapped of this state."

Gains have been made on all fronts but the individual battles which we have left for today will and must continue. And yet, as we fight, the picture of the total campaign becomes clearer. We find that the army on our right and left flanks attack the same enemy. We begin to see that better cooperation among ourselves will give us greater strength. And, so we meet here today with all our forces represented. We meet to consider future goals and activities. Let us reason well together, because the fate of many in the future depends upon our actions here today.

*ECONOMIC OPPORTUNITY AND THE IMPLICATIONS FOR REHABILITATION

Robert Shackford
District Director
Community Action Programs
Office of Economic Opportunity

The primary purpose of the programs under the economic act are to provide a means of reducing the number of persons now in the poverty group who are in this category because of circumstances beyond their control.

It is not an effort to eliminate poverty, in its entirety, for it is recognized that all poverty cannot be eliminated. What does poverty mean? It means a lot of different things. As example it means taking your child to an eye clinic and waiting only to be told to return at another time. To wait and watch and get nothing done.

The need to provide ways to reduce the health problems among the disadvantaged citizens and to put them in a position of productive citizens was stressed. The role of the school in working with the children and parents in the low income group was emphasized.

The speaker also stressed that in this day of high economic standards and a time of plenty, too many families were in an income bracket of $1,000 to $3,000 per year. This level of income hardly provides the barest essentials for food and shelter let alone medical care.

ADDRESS:
EXCERPTS FROM AN ADDRESS:

HONORABLE LEE H. HAMILTON
United States Congressmen

The evidence is beginning to emerge of the plus factors of hiring the handicapped. Their motivation is excellent. There is one-third better chance that an impaired worker will be on hand for the starting bell.

In 1964, 120,000 persons were rehabilitated. Ninety-thousand of these persons had no previous wages, and 21,000 had been dependent upon public welfare.

According to our most recent reports, almost 135,000 disabled persons were restored to their job in 1965.

The accomplishments include legislation, which now goes through Congress easily . . . almost unanimously. The legislation was inspired, not by government, but by private agencies like the Red Cross Institute for the Crippled and Disabled, the Rehabilitation Center in Cleveland, and Milwaukee's Curative Workshop.

The year 1965 has seen this legislative work proceed, under the amendments to the Social Security Act, needy individuals, dependent children and the blind can count on expanded medical assistance. Injured workers can count on benefits if their disability is expected to last more than a year. State vocational rehabilitation agencies can count on federal reimbursement for expanded services to disabled workers. The parents of a handicapped child can claim $600 income tax deduction if that child is in a public or private institution, even if the child is over 21.

The responsibility for an effective program of rehabilitation to the handicapped rests squarely upon our states and our local communities.

In the nation, we face a backlog of over two million who need today the benefits of rehabilitation. In 1965, 270,000 new persons will become disabled. Some 18 million persons—one in every ten—suffer from mental disorders severe enough to need psychiatric treatment.

More that 18 million persons in the United States have physical disabilities—and only 7 million of these people are gainfully employed.

In 1965, Indiana has raised enough state funds, just over $600,000 to earn only about 23 percent of its federal allotment. To be quite candid with you, according to statistics for 1965, released in August by the United States Commissioner in Indiana, Indiana ranked 53rd in the number of cases served per 100,000 residents; 49th in number of rehabilitants per 100,000 and 54th in number of counselors per 100,000 disabled persons. We have our work cut out for us.

The average person rehabilitated will pay Uncle Sam $7 in income tax for every dollar Uncle Sam spends in rehabilitating him.

The story needs to be told of the Labor Department's study of 11,000 handicapped and 18,000 abled bodied workers performing similar tasks. The results showed the handicapped outproduced the able bodied by a ratio of 101 to 100. They had 6 percent fewer disabling job injuries; and their absenteeism was no more than for the able bodied.

In America, we have launched upon our intensely curative period in rehabilitation. That rehabilitation in Indiana is up to you.

And the test of rehabilitation is not in the statistics, not in the rank that Indiana has among the 50 states, . . . it's in the kind of man you turn out.

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* A condensation of Mr. Shackford's address

INTERNATIONAL CODING

The Rehabilitation Codes, Inc.,
Maya Riviere, D.Phil. (Oxon.)
Executive Director

A number of systems of international coding exist today for identifying, recording, and exchanging information from one to another country on such topics of common interest as the weather, vital statistics, road signs, and workers' wages related to the number of hours it takes to earn daily commodities like a loaf of bread or a pair of shoes. These codes, which may take the form of symbols, works, numbers, etc., make it possible to exchange reliable and comparable information across the barriers of geography, language, and national boundary.

The World Health Organization under the United Nations uses the International Statistical Classification for Diseases, Injuries, and Causes of Death to gather comparable data on conditions affecting health and life, which they can then correlate with other data on local living conditions to provide the basis for programs of preventive medical and other care. These codes are revised every ten years, and over the decades some further categories have been added to show the nature and extent of injuries (the "N" and "E" Codes), early and late effects of chronic disease, and useful details on hospital admissions without treatment, for vaccinations, for checking use of prostheses, etc. None of these added codes was designed specifically for use in rehabilitation but they pointed to the need for identified details other than straight diagnostic or underlying pathology, where the patient continues to live with residual effects of injury or disease.

In 1949 the U. S. Public Health Service responded to a request from WHO to all member nations to appoint a national data-gathering agency with *ad hoc* subcommittees to work on problems needing collection and analysis of health data. The Surgeon General appointed the National Committee on Vital and Health Statistics, and one of the subcommittees established in 1951 concerned the development of an impairment code which would be useful to indicate the current state, the permanence of the impairment, the causative pathology, and the person's rehabilitation potential.

Just as the World Health Organziation sought to secure agreement among nations on how to identify and collect health data, so in any other exchange of information and regardless of the size of the geographical area, the crux is agreement upon the information needed for exchange, the uses to which it may be put, and the procedures for encoding it so that the decoder will interpret it precisely as the encoder meant it to be understood.

The basis for international coding is no different from what goes on over the backyard fence in a morning chat between two housewives, except that the two women will already be in rapport on the context within which they are discussing their mutual interests, that is, they will already be talking "the same language." If we extend the backyard to any larger geographical area, communication will depend upon friendly agreement to use certain symbols, definitions, and delimited contexts for the exchange of mutually interesting information.

When a State government looks to planning services on a statewide pattern, the various State departments—health, welfare, mental hygiene, education, correction, etc.—each may constitute an "international" barrier to communication. Or the barrier may lie at the county line where payment is authorized and service implemented. Residence requirements may result in empty beds in hospitals in one county, while waiting lists lengthen in an adjacent county. A State plan must examine artificial barriers, whether they are the result of law, local regulations, administrative decisions, professional practice, or community bias. Some may be simply a matter of history and without need or reason today.

A State can approach long-range planning only if there is available accurate information on the needs and resources, and their distribution statewide. Although every government office collects information and puts out reports, one must question the validity of most statistical statements, knowing the chaotic record-keeping practices in facilities which provide medical and social services. When the Association of Rehabilitation Centers inventoried several hundred rehabilitation programs across the country in their Voluntary Reporting research project the first analysis of information they reported showed that while fiscal activities, which are necessarily audited annually, could be reported on fairly easily, the three details on which the programs had the greatest difficulty were the age, sex, and diagnostic category of their rehabilitation clients. It would appear that the business side of rehabilitation is being better documented than the history of the people for whom

the services were organized. How then is it possible to tell what the money buys?

Today, increasingly, the financial support for health and social services comes from the Federal government, which in turn must collect information from the States. Here the problem is compounded by fifty-two since State reporting can be only as reliable as the data collected within each State.

Recognition of these problems has led to State plans to regionalize service and, in a number of instances, to compile valid information on statewide needs and resources, sometimes by creating registers of persons or of facilities, sometimes by special surveys and research studies. Ultimately, since service is given to the individual, the individual's case record holds the sole potential for securing comparable details from which data can be accumulated reliably, and this would imply that the details were planned; recorded in a consistent manner on the stated dates when the individual needing service was examined, evaluated, served, and again evaluated to see what effect the service had; excerpted consistently; and added to parallel details from other similarly prepared case records, to form a body of valid information. As long as the individual case record so kept is the unit of exchange, all barriers of profession, facility, diagnostic category, payment source, language, and geography can be crossed.

The greatest obstacle to this procedure is failure of academic curriculums to teach anything about the reason for keeping records, the uses of records in implementing service, or the techniques of recording information to be looked at and understood by anyone other than the writer. It is apparently assumed that anyone who can write can keep a record. While it is notorious that physicians' handwriting is the subject of very old jokes, the fact that few college-level students have more than a rudimentary knowledge of English is further complicated by the fact that most professionals in the health and social services neither speak nor write English when carrying out their professional duties. Each is trained in his own discipline, with its own ritual, secret language, and mystique. Not even within the disciplines have record forms been standardized or agreed upon nationwide for entering the jargon and numeric symbols in which their own examinations and procedures are expressed. Working within a single discipline it is possible that communication occurs, but what happens when an individual's problems necessitate personnel trained in one discipline working with those from another?

The usual case record consists of a voluminous assortment of separate departmental and individual professional therapist's narrative notes, in no logical order or progression from first to last contact: the pity is that the record does not reflect the excellence of the care which may be provided, or that the essential information is so well hidden or only carried in the staff members' memories, instead of being deposited in an easily recoverable form in the case record. No body of knowledge on rehabilitation or on patients' use of service can be accumulated as long as this is the customary way of keeping a "case history." The current notes are not even a reflection of the patient's current state, but only the therapist's.

A further barrier to communication has been created by the advent of what we call "rehabilitation," for this is not a discipline with a defined corpus of knowledge taught in a formal curriculum, but rather a concept and an organization of services which cut across all disciplines and professions. In addition, it is oriented towards life in the community, rather than pathology in the hospital. Here a variety of professional personnel may be drawn upon in a given instance as needed by an individual. Here their separate procedures must be integrated and implemented in terms primarily of his residual function and his concept of his own life. Nothing has prepared the professionals for this traumatic experience of having to consider the patient as a person capable of having opinions or making decisions about his own anatomy. The conflict implicit in each professional appropriation of a portion of that anatomy or some area of function is now exacerbated by their having to submit to his occasional "why?" or other demand for an explanation of what is going on. They have not the vocabulary to explain their work to him and they continue to discuss him among themselves in their separate "foreign languages" which eventually record in the case record their narratives on the performance of whatever segment is the special interest of each—organ, muscle, body system, IQ, etc.

Until a formal rehabilitation curriculum exists, what is needed is a period of self-discipline for all the professional staff working in rehabilitation. This means the willingness to take time to sit down and identify the kinds of information which will help them understand the person they try to serve and serve him within the cultural context where he is accustomed to live. Fundamental to

this is their understanding and acceptance of the fact that they, their therapeutic techniques, and the treatment institution are the abnormality for the person who is receiving the service: his idea of life is his home, family, and community. The disease or injury and any residual limitation of function is an abnormality: he cannot build his life on function which has been lost or damaged. The important thing now is what he can do. In the community this is understood better than in the hospital: the employer does not hire on the basis of what the employee is *not* going to contribute. This is why the national and state programs on "Employ the Handicapped" are now out-of-date: it is time that they were re-titled to express the rehabilitation concept of what a man *can do* in spite of having some disability. Otherwise, the impression is given that the program means the person has not been and cannot be rehabilitated, that he is damaged goods and won't be able to carry any part of his weight for an employer. The word "handicap" stigmatizes the individual and is a detrimental label which libels his capabilities, his motivation, and his residual functions. This negates everything which rehabilitation programs are trying to present to the public. Perhaps this is why most programs lack financial support: they do not tell the community what rehabilitation *can do*. However, in recent months there has been increasing acceptance of a concept of service to the effect that professional personnel and treatment institutions are specialized tools of the community, whereas in the past both have seemed to consider themselves as separate from the community. Pressure of increasing caseloads, increasing statutory benefits, and continuing scarcities of trained staff have required re-orientation from the traditional emphasis on institutionalization to increased care in the community extended from the institution in cooperation with community programs, many of which give some training to home visitors, neighborhood shoppers, nurses aids, and other supportive staff.

It now becomes all the more important that the professionals cease their isolationism, learn to interpret their work in everyday terms which can be understood by their supportive aides, the family members who may have to continue home-care and even the patient. Referrals to community agencies will be more promptly accepted if the referral information is easily understandable, concise, and reported in an agreed-upon form incorporating information directed at the service to be continued. Staff time preparing referral reports will be reduced if the usual voluminous jargonistic letters are replaced with a simple referral form.

In an attempt to provide records which might be a direct medium of communication, a research project was begun in 1957 by a private foundation in New York, The Association for the Aid of Crippled Children, with financial support from the (then) Office of Vocational Rehabilitation and subsequently the Easter Seal Research Foundation. Over the years the project became known as The Rehabilitation Codes, and the following description outlines the content and purposes of this program, which continues now in its ninth year (1965):

The Rehabilitation Codes are a longitudinal record-keeping system focused upon the individual needing services, rather than upon his pathology primarily, the treatment institution, or the professional techniques. Under development since early 1957 the system comprises classifications of information and serial recording procedures which have been twice field tested, taught in eight one-week conferences to some 500 department heads of academic, clinical, Federal and State department program heads, and used by the State of California as the basis for the development of a statewide data-gathering system for their Health and Welfare Agency. The Codes are currently under definitive revision, nearing operational status.

The Rehabilitation Codes, Inc., is a legal structure established April, 1964 to sponsor continuation of work on this records system, which was initiated by studies on the kinds of information needed for evaluation of disability and implementation of service. In over 200 programs visited across the country, so little basic information about the person and his family and community life was found in the case records that before completing development of procedures to evaluate disability, the project committee felt it necessary to organize the classifications which now appear on the *Personal History* and *Health History* serial record forms. These supply the background of the person's accustomed or appropriate way of living, for decisions on services to help him take up or resume this life must be made within the context of what life means to him and his family. These two histories use the same identifying headings which appear on all Rehabilitation Codes serial record forms, so that all can be correlated and the individual's status compared for pre-service or accustomed activities and achievements, response to services, discharge date levels of function, follow-up in the community, re-admission if necessary,

etc., simply by dating each column appropriately on the serial record form. These two forms are factual, rather than evaluative.

The Evaluation-Service form was designed specifically for use by the multiprofessional group who during the period of active service meet periodically to discuss and appraise the person's progress. No single person or professional can answer all the questions implied by its classifications. When case conferences are called, the rehabilitation coordinator, the medical records librarian, or whoever serves as group recorder, participates in the group's discussions, and when they agree upon selection of a coded description which represents the synthesis of their opinions on a classification of information, the recorder enters the code number upon the serial record. From one to another conference the function of recorder may be assumed by any member of the group.

The fourth major section of the Rehabilitation Codes is the *Impairment-Cause-Etiology Codes.* These grew out of continuous contact between the research project and the U. S. Surgeon General's Subcommittee on the Physical Impairment Code, of the National Committee on Vital and Health Statistics. The Subcommittee had been appointed in 1951 following a request from the World Health Organization to the Surgeon Generals of Public Health Services in all member nations in connection with the periodic revisions of the International Statistical Classification which was described above as an example of international coding. The Subcommittee Chairman participated in discussions which led to the initiation of the Rehabilitation Codes project and has continued to date on the government committee and (now) Board of Directors of The Rehabilitation Codes, Inc., while the project director was asked to serve on the Surgeon General's Subcommittee starting 1957. In 1959 the Surgeon General's Subcommittee turned over work to complete the Impairment Code to the project, and the International Statistical Classification was agreed on for the "Cause" section of this three-section Code. Working committees were appointed of specialists in the several areas of impairment, some 280 professionally eminent persons giving more than 2550 all-day work sessions between 1959 and 1962 without remuneration. All committees worked within the concepts of the Rehabilitation Codes, emphasizing unimpaired function first and after developing a definition of unimpaired function for each category, then proceeded to study descriptions in terms of absence or total loss of function, measureable limitations of function, and those (to date) un-measureable dysfunctions which are evidenced on a specific date. The draft prepared by the Surgeon General's Subcommittee in 1955 was re-oriented from a (traditional) preponderance of entries on impairment of musculoskeletal function to a developmental approach starting with functions of awareness, the processes of learning including communication, the thinking processes, and personality, as being more influential for the individual's control of his own life than the various bodily systems or even mobility and weight-bearing.

In 1961 the National Institute of Neurological Diseases and Blindness began support of one section of the Surgeon General's Impairment Code, and this Program on Communicative Disorders is approved into 1968. A parallel support for the code section on Impairment of Visual Function began in June, 1965. Both programs include further refinement and development of the Impairment Code, field-testing of the code and Manual of Instructions for Coding, and national and regional conferences to bring the material before a wide professional variety of Federal, State, local, and non-governmental department chiefs and academic department directors. From field testing of the entire Rehabilitation Codes record-keeping system and teaching its use in ten conferences, a useful application of the Codes has been as a "thinking" tool by means of which personnel from diverse agencies learn to identify their own records needs and requirements, their points of common information which might all be coded alike, and their points of further information unique to their own departments, which can be added to the common body of data on each patient.

This was the procedure followed in the State of California where the Governor merged the State Departments of Public Health, Social Welfare, Mental Hygiene, and Rehabilitation into a single Health and Welfare Agency: in 1964-65 the State Department of Public Health, Bureau of Hospitals, which was responsible for licensing rehabilitation facilities to provide care under categorical aid programs and for approving applications for Hill-Burton funds, contracted The Rehabilitation Codes, Inc., to carry on a series of six "thinking" workshops—three in May-June, 1964 for the personnel of the four State departments, personnel from Southern rehabilitation facilities, and personnel from Northern rehabilitation facilities, and three the following January for the same three groups. The result was agreement to set up three working committees on "Re-

habilitation Records" to develop a common body of information to be recorded for every recipient of service, describing his status at admission and at discharge dates, with follow-up in the community afterward. This common form went into field testing January, 1966 for one year, to be re-assessed and revised, and put into regular use starting January, 1967.

The Codes provide a common language—

- to describe the person primarily, rather than the pathology, the treatment environment, or the professional techniques
- to replace the jargon taught in the various disciplines now concerned with multi-professional synthesis in patient care
- to improve communication among the professions and between them and the person served, his family, and the community

The Codes are adaptable to all programs

- they provide an effective structure for longitudinal records of persons served over long periods of time because of chronic problems.
- they reduce the cost of staff time now spent on narrative records, reports, referrals, and correspondence which are largely unproductive in conveying information about the case material.
- they codify in forms immediately usable in any system of data encoding, processing, and decoding, the necessary details for

  measuring the quality of services given program planning and evaluation.

  professional and non-professional orientation institutional and community use.

  research needed for prevention, epidemiology, and community health.

The Codes' purpose is to improve service

- by individualizing evaluation and implementation according to the person's needs within his own cultural context.
- by obtaining the body of information necessary for professional personnel to understand his cultural context and way of life.
- by building a longitudinal record (equally understood in the institution and community) which permits comparisons of his functional levels prior to impairment, before service, at specific dates during service, follow-up in the community, and at case closure.
- by adding comparable data from one case record to another, which will permit accumulation of information on an agency-wide, area-wide, nationwide basis, for formulation of a rehabilitation curriculum and for research on new techniques and procedures and implementation of their use in rehabilitation programs.

This has been a report on one attempt to apply commonsense to some of the problems implied in "coding" or preparing information for exchange across international, interprofessional, and intramural barriers in order to serve people more effectively when health and social problems require outside help.

PANEL DISCUSSIONS

NEW LEGISLATION AND PROGRAMS AFFECTING THE HANDICAPPED

(Reported by Margaret Warner, M.P.H., Health Education Consultant)

Panel #1: Wednesday, October 6, 1965 — 2:00 P.M.

Moderator: Merrill C. Beyerl, Ph.D., Vice-President, Ball State University, Muncie.

Participants. Leslie Brinegar, Director, Division of Special Education, State Department of Public Instruction.

Gayle S. Eads, Director, Division of Vocational Rehabilitation, State Department of Public Instruction.

Keith Collins, Assistant Chief, Employment Service, Indiana Employment Security Division.

Robert W. Spaulding, Director, Division on Mental Retardation, Department of Mental Health.

The opportunities available now for furthering new programs and strengthening and expanding old ones provides a strong challenge to the leadership in Indiana in regard to the development of special programs for the handicapped. There is an urgency for more coordinated effort among all the agencies responsible for services to the handicapped. Increased emphasis is placed upon the Employment Service as a center of manpower and a greater responsibility in assisting with the employment of the handicapped.

There is a greater recognition of the significance of mental illness and tuberculosis and the concurrent problems of a social and economic nature which result. Provision is made for the development of health services and facilities that are closer to the people.

Concern is shown for the socially handicapped, as well as the physically and mentally handicapped and rehabilitation is taking on a new role within the welfare services.

Opportunity for programs and services for children of pre-school age are made possible, thus making it possible to establish services which will prevent disability as well as correct or rehabilitate.

There are funds available for training of personnel needed so much to fill the jobs for special education classes and other rehabilitation positions. The need for a greater number of persons at the college level is acute. At the present time, there are 2,000 in training in the mental health field. The outlook ahead is toward broadening training opportunities in the colleges and universities. A greater effort will be made to shift the public focus from pathology to people. The challenge is with us to strengthen existing programs and to develop new where practical and necessary.

Panel #2: Wednesday, October 6, 1965 — 3:15 P.M.

Moderator: Otis R. Bowen, M.D., House Minority Leader, Indiana General Assembly, Bremen.

Participants: Calvin Wilcox, Assistant Director, State Department of Public Welfare, Indianapolis.

Stewart T. Ginsberg, M.D., Mental Health Commissioner, Indianapolis.

Freeman D. Ketron, President, Indiana Rehabilitation Association, Indianapolis.

A. C. Offutt, M.D., State Health Commissioner, Indianapolis.

PANEL QUESTIONS

Question

1. What are the implications for rehabilitation under the Health Insurance Act (Medicare)?

Although no one can say for certain what the effect will be at this time there are certain provisions in the act that appear to have implication for rehabilitation.

Under Title XIX, Section 1901, the Act provides for (1) medical assistance to families with dependent children and of aged, blind, or permanently and totally disabled individuals, whose incomes and resources are insufficient to meet the costs of necessary medical services and (2) rehabilitation and other services to help such families and individuals attain capability for independence or self-care. A sufficient sum to carry out this provision is authorized to be appropriated.

Under Title II—Other Amendments Relating to Health Care

1. Section 202—*Increased services to crippled children* are provided under the provision that services be extended to children of all

parts of the state. For this service the following amounts are authorized to be appropriated:

fiscal 66—$45,000,000.
fiscal 67— 50,000,000.
fiscal 68— 55,000,000.
fiscal 69— 55,000,000.
fiscal 70 and each fiscal year thereafter $60,000,000.

2. Section 203, Part 2, Title 2, Title V Amended—Section 516—Provides for the training of professional personnel. Grants can be made by the Secretary to public or non-profit institutions of higher learning for training professional personnel for health and related care of crippled children, particularly mentally retarded children and children with multiple handicaps.

   The following amounts are authorized to be appropriated:

   fiscal 67—$ 5,000,000
   fiscal 68— 10,000,000
   fiscal 69— 17,500,000 and for each fiscal year thereafter.

3. Section 205, Part 4, Title V—Amended—Section 532—*Special project grants for health of school and pre-school children.* The Secretary is authorized to make grants to the State Health Agency and (with the consent of such agency) to the health agency of any political subdivision of the state, to the state agency of the state administering or supervising the administration of the state plan approved under Section 513, to any school of medicine (with appropriate participating school of dentistry), and to any teaching hospital affiliated with such a school, to pay not to exceed 75 per centum of the cost of projects of a comprehensive nature for health care and services for children and youth of school age or for pre-school children. Projects to be eligible must provide for (1) coordination of health care and services provided under it with, and utilization of, other state or local health, welfare, and education programs for such children, (2) for payment of the reasonable cost of inpatient hospital services provided under the project, and (3) that any treatment, correction of defects, or after-care provided under the project is available only to low-income families or for other reasons beyond their control; and such project for children and youth of school age shall not be considered to be of a comprehensive nature unless it includes—screening, diagnosis, preventive services, treatment, correction of defects, and after-care both medical and dental.

   For this service the following amounts are authorized to be appropriated:

   fiscal 66—$15,000,000
   fiscal 67— 35,000,000
   fiscal 68— 40,000,000
   fiscal 69— 45,000,000
   fiscal 70— 50,000,000

Title II

Part 2—Implementation of Mental Retardation Programs

Section 211—Provides for assistance to state in initiating the implementation and carrying out of planning and other steps to combat mental retardation.

For this purpose the following amounts are authorized to be appropriated:

fiscal 66—$2,750,000
fiscal 67— 2,750,000

Part 3—Public Assistance Amendment Relating to Health Care

Section 221—Provides for the removal of limitations on federal participation in assistance to individuals with tuberculosis or mental disease in public medical care facilities.

Part 4—Miscellaneous Amendments Relating to Health Care (Special program grants—health study of resources relating to children's emotional illness)

Section 231—Provides upon the recommendation of the National Advisory Mental Health Council and the advice of experts in pediatrics and child welfare, the Secretary is authorized to make grants for carrying out a program of research into and the study of our resources, methods, and practices for diagnosing or preventing emotional illness in children and of treating, caring for, and rehabilitating children with emotional illness. It further provides for the grants to be made to one or more organizations provided the organization will undertake and conduct, and/or if more than one organization is to receive a grant, they have agreed among themselves to undertake and conduct a coordinated program of research as indicated above. (This means single agency will conduct or multiple agencies will conduct.)

Question

2. What are some of the present weaknesses of the rehabilitation program in Indiana? Is addi-

tional legislation needed to correct any of these weaknesses?

1. Lack of adequate training to prepare individuals to work as members of rehabilitation teams in coordinated programs.
2. Job opportunities and employment of the handicapped still proceed at a slow pace—with automation and other contributions that affect the labor market—this problem becomes more and more complicated.
3. A greater understanding is needed of what is meant by total rehabilitation.
4. Lack of a planned procedure in communities to achieve proper referral to available services.
5. Lack of an over-all state plan for rehabilitation in Indiana that takes full advantage of existing resources and includes plans for correcting.

Question

3. Are more rehabilitation centers needed in Indiana?

There might appear to be a need for more rehabilitation centers, however, the question might be posed, "are we utilizing all the resources and services available to their fullest capacity?" It does not appear that building rehabilitation centers is the important factor. The most important factor is the availability of a total range of rehabilitation services in communities where the people are located who need or require these services. The practicing physician, with a concept of rehabilitation as a part of total patient care appears to be the key to an effective program.

Question

4. Many individuals feel that there is a shortage of trained rehabilitation personnel in Indiana. How can this situation be improved?

It seems the first step in determining the need for additional personnel is to analyze existing programs for overlapping services and to make an effort to coordinate services in such a way that greater utilization of existing personnel is made. Secondly, it seems that a concentrated effort is needed to recruit new personnel into the field to fill the void of those retiring and those leaving the field. Greater effort is needed to interpret the job opportunities available in this service area for the handicapped. A training program that prepares various disciplines to work as part of a rehabilitation team and not just a—therapist counselor, etc. would be imperative in the correction of the situation.

Question

5. What is the role of the Commission for the Handicapped? How can its influence be strengthened?

The Commission for the Handicapped has been given specific responsibilities by the state legislature and has a primary role of the coordination of rehabilitation services in the state of Indiana. It brings together those individuals, who have a responsibility for operational programs along with certain consumer group representatives. It makes possible exploration of need and joint planning to meet these needs. In answer to the question—How can its influence be strengthened? It should evaluate its current efforts, review the legislative directive, determine more specific areas for concentrated effort and interpret for the public rehabilitation problems and accomplishments. The commission has done a good job in the past—I assure you that the State Board of Health will attempt to help it do a better job in the future.

Question

6. Is it logical to consider rehabilitation as an integral part of a total public health program?

It seems that the methods and skills used in the area of rehabilitation are the same as those normally used in the practice of public health. Further many of the services and resources utilized are of a preventive nature. Also, the problems of rehabilitation are a concern to the total community and in the broad sense of public health are naturally one of the complexes of the total public health picture. Since leadership and development are concerns and responsibilities of public health, it appears this is logical to consider rehabilitation as an integral part of a total public health program.

I find it extremely difficult to identify differences between the objective of public health and those of rehabilitation—Also the general methods used to achieve these objectives are quite similar—The differences occur only when we consider the specific techniques and skills and even within public health and within rehabilitation these techniques and skills vary.

SUMMARY

Leaders in Indiana are not without plans for action. Many projects have been written, many

are in process; some have been approved and some rejected. Reappraisal of problems and resources are high on the list of priorities. Andrew Jacobs, U. S. Representative, pointed out the significant size of the problem of providing educational services to children in a speech recently presented to public school and state school administrators. "In Indiana," he said, "it is estimated that over 142,000 children are in need of special education programs. Only 38,000 are in such programs. In other words, only 32 per cent of the handicapped Hoosier youngsters are getting the kind of special education attention they need and deserve."

Although projects are being formulated, situations reappraised, agencies and communities geared for action, there was general consensus that much hinged on the states willingness to pay its share, whether it be ten, twenty-five, or fifty per cent. Last year $2,000,000 failed to reach Indiana's Vocational Rehabilitation Agency due to the state's failure to provide its share. When returns on vocational rehabilitation investments have been shown to be ten to one, such a failure seems indicative of a disastrous kind of economy. In the last analysis, Indiana's disabled citizens will benefit from the vast amounts of federal funds available only if necessary and proper action is taken both legislatively and administratively.

AWARDS PRESENTATION

The Governor's Rehabilitation Awards Program was designed to honor deserving persons and organizations in Indiana's effort to increase employment opportunities for the handicapped. This program was constructed to correlate with the awards program of the President's Committee on Employment of the Handicapped. Persons nominated for a Governor's Award will also be considered for nomination for the appropriate national award of the President's Committee.

A nomination for an award can be made to the Commission for the Handicapped by any Indiana agency or individual working with the handicapped; however, I wish to point out that the commission feels that it is not mandatory that all awards must be presented each year. The presenting of an award is determined by the nominations received and the appropriateness in relation to the established criteria for each award. This year there are four awards to be made.

I wish to extend thanks to the Awards Committee and the Commission for the Handicapped for their sincere effort in recommending one of the nominated candidates for each award that is to be presented tonight.

Distinguished Service Awards

The first award to be presented is that of the Distinguished Service Award. This award may be presented to any Indiana organization, agency, or individual making an outstanding contribution toward advancing the employment of the handicapped.

This award is given to extend public recognition for meritorious service in promoting better public understanding of the employment capabilities of the handicapped. It is hoped that, through this recognition, others will become interested, public understanding enhanced, barriers removed, and opportunities expanded for suitable employment of the handicapped.

We have two recipients of this award this year. One to an individual the other to a corporation.

The individual to receive this award is Jacob L. Caskey, Vocational Principal and Director of Athletics at the Indiana School for the Deaf. For thirty-four years, he has made a tremendous contribution in the vocational rehabilitation and training of deaf youngsters to be self-supporting, self-respecting, independent individuals.

It is with great pleasure I present a Distinguished Service Award to Mr. Caskey for his excellent tutelage and vocational training which has enhanced the employment of handicapped individuals and which in turn has made for better public understanding of the employment capabilities of deaf people. Mr. Caskey.

* * * * * *

The second Distinguished Service Award is to be received by Mr. Sherwood J. Smith in behalf of the Whirlpool Corporation of Evansville, Indiana, Manufacturer of Electrical Appliances.

This company has made a significant continuing contribution to better understanding the employment capabilities of the handicapped. A well-developed philosophy of community support and participation in worthwhile activities, which includes substantial contributions of time, money, and leadership to the cause of the handicapped, has been exemplified.

Over three hundred people with physical limitations are employed within Whirlpool's manufacturing plants. Everything reasonable that can be done on the job to rehabilitate an impaired worker is done, and consideration to physical handicaps is always a criterion in placing an individual in a position.

In addition Whirlpool makes employment possible for approximately one hundred employees by providing sub-contract work to sheltered workshops.

It is a privilege for me to present a Distinguished Service Award to the Whirlpool Corporation in recognition of its effort to remove barriers and expand opportunities for suitable, useful employment of the handicapped. Mr. Sherwood J Smith.

Public Personnel Award

The next award to be presented is the Public Personnel Award.

This award is conferred on an individual employed in a public agency located in the State of Indiana. The agency can be federal, state, local, municipal, or a public school system.

The purpose of the award is to honor a personnel official or other worker who is making exceptional contributions to the employment of the handicapped in the public agency where he is employed. It is hoped that this award will encourage employment of qualified handicapped persons in the public service consistent with com-

petitive qualification policies, and that an increase in opportunities for the handicapped will result.

The recipient of this year's award is Mr. Gayle S. Eads, Director, Division of Vocational Rehabilitation, Indiana State Department of Public Instruction.

Mr. Eads has made an outstanding contribution to the state's program of rehabilitation by the reorganization and the facilitation of procedures of the Division of Vocational Rehabilitation. Since May of 1961, the professional staff has been increased by 34 per cent; professional standards of the staff have been raised; services to the handicapped have been greatly improved. Through his guidance, over 1700 handicapped people went to work as independent citizens because of the efforts of the Division.

Not only has he made a marked influence on the employment of the handicapped in general but has set an example for a state agency by proving that "Ability Counts" by hiring qualified handicapped people within his own organization.

In recognition of his foresight and the fruits of his labor: it is my pleasure to present this award to Mr. Gayle S. Eads. Mr. Eads.

The Governor's Trophy

The Governor's Trophy may be awarded each year as a special honor to a handicapped Hoosier who has surmounted his or her own handicap to become a useful citizen, and who has helped to encourage, inspire, or facilitate the employment of other handicapped persons.

The Governor's Trophy for 1965 is being presented to Mr. Crayton E. Mann, Assistant Administrator at St. Margaret Hospital, Hammond.

Mr. Mann was a native Hoosier—born and schooled in Evansville, a graduate of Evansville College and of Northwestern University. He became a quadraplegic as the result of a spinal cord injury sustained in a diving accident in the Ohio River in September, 1954.

After six years as a patient in several hospitals he was able to overcome his disability and return to his former profession. Although he has limited use of one arm and hand, no use of the other and only slight use of both legs, he is able to competently perform his duties, going about the entire hospital in his motorized wheel chair. Through his encouragement and example, he has helped to inspire and facilitate the employment of other handicapped persons.

Ladies and gentlemen, it is my pleasure to present the Governor's Trophy to the *"Handicapped Hoosier of the Year,"* Mr. Crayton E. Mann.

CLOSING REMARKS AND DISMISSAL

Neal E. Baxter, M.D.

Ladies and gentlemen, we are about to come to the end of the Governor's Fifth Conference on the Handicapped. During this time, we have had the opportunity to use the fine facilities in the Terre Haute area, attend sessions of special interest to us and to meet with our friends and professional constituents. We have explored the problem of What's New In Rehabilitation, through the efforts of our excellent speakers and panelists, and through our own active participation and assimilation of knowledge.

I believe a philosopher by the name of Elbert Hubbard might have summarized this conference, around 1900, when he expounded on "The Radiant Life." He wrote, "I wish to be simple, honest, natural, frank, clean in mind and clean in body, unaffected—ready to say 'I do not know', if it so be—to meet all men on absolute equality—to face any obstacle unafraid and unabashed. I wish to love without hate, whim, jealousy, envy or fear. I wish others to live their lives too—up to their highest, fullest, and best. To that end I pray that I may never meddle, dictate, interfere, give advice that is not wanted, nor assist when my services are not needed. If I can help people, I will do it by giving them a chance to help themselves, and if I can uplift or inspire, let it be by example, and suggestion, rather than by injunction and dictation. I desire to 'Radiate Life'."

Thank you all for your attendance and participation and continue to grow throughout the year in the same cooperative spirit which has been displayed at this conference.

The Governor's Fifth Conference is now adjourned.

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